STATE OF MICHIGAN

IN THE SUPREME COURT

ADVOCACY ORGANIZATION FOR PATIENTS & PROVIDERS,

Plaintiff-Appellant,

vs.

ALLSTATE INSURANCE COMPANY, *ET AL.*,

Defendant-Appellees.

Supreme Court Case No. 124639
Court of Appeals Case No. 231804
Eaton County No. 96-001409-CZ

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Dated: **August 19, 2004**

TABLE OF CONTENTS

Page

NAS
AMIS
FIRM

DRAMIS,
OUGHTON
TYRE, P.C.
TREE ROAD
MICHIGAN
-4207

517-394-7500
394-7510

TABLE OF AUTHORITIES

Cases **Page(s)**

INAS
AMIS
W FIRM
, DRAMIS,
BOUGHTON
NTYRE, P.C.
E TREE ROAD
, MICHIGAN
11-4207
E 517-394-7500
7-394-7510

Statutes

NAS
AMIS
FIRM

DRAMIS,
OUGHTON
TYRE, P.C.
TREE ROAD
MICHIGAN
1-4207

517-394-7500
-394-7510

STATEMENT OF JURISDICTION

The Coalition Protecting No Fault does not contest this Court's Jurisdiction.

NAS
AMIS
FIRM

DRAMIS,
OUGHTON
TYRE, P.C.

TREE ROAD
MICHIGAN
1-4207

517-394-7500
-394-7510

STATEMENT OF QUESTIONS INVOLVED

I. IN DETERMINING WHETHER PROVIDER FEES ARE REASONABLE, MAY A NO-FAULT INSURER CREATE AND IMPOSE A DEFINITION OF "REASONABLENESS" WHICH IS BASED ON A SET FORMULA, WHICH DOES NOT TAKE ANY INDIVIDUAL CASE FACTORS INTO ACCOUNT AND WHICH HAS THE EFFECT OF CREATING A FEE SCHEDULE?

Plaintiff-Appellant answer "No."

Defendants-Appellees answer "Yes."

The Trial Court would answer "Did not answer."

The Court of Appeals answers "Yes."

DRAMIS, OUGHTON TYRE, P.C.
TREE ROAD
MICHIGAN
1-4207

517-394-7500
-394-7510

I. INTRODUCTION

The Coalition Protecting Auto No Fault ("CPAN") is a broad-based group formed to preserve the integrity of Michigan's model no-fault automobile insurance system. CPAN's member organizations and associations range from major medical organizations and patient advocacy groups directly involved in first-party no-fault issues, to consumer groups concerned with ensuring that the system remains able to provide prompt adequate and assured benefits. CPAN's membership is comprised of thirteen medical provider groups and twelve consumer organizations:

CPAN: Coalition Protecting Auto No-Fault	
Medical Provider Groups	**Consumer Organizations**
Michigan Academy of Physicians Assistants	Brain Injury Association of Michigan
Michigan Assisted Living Association	Disability Advocates of Kent County
Michigan Association of Centers for Independent Living	Michigan Paralyzed Veterans of America
Michigan Brain Injury Providers Council	Michigan Partners for Patient Advocacy
Michigan Chiropractic Society	Michigan Protection and Advocacy Services
Michigan College of Emergency Physicians	Michigan Rehabilitation Association
Michigan Dental Association	Michigan Citizens Action
Michigan Health & Hospital Association	Michigan Consumer Federation
Michigan Home Health Care Association	Michigan State AFL-CIO
Michigan Orthopedic Society	Michigan Trial Lawyers Association
Michigan Osteopathic Association	Michigan Tribal Advocates
Michigan Orthotics and Prosthetics Ass'n	Michigan UAW
Michigan State Medical Society	

NAS
AMIS
Y FIRM
DRAMIS,
BOUGHTON
ITYRE, P.C.
TREE ROAD
, MICHIGAN
1-4207
517-394-7500
-394-7510

CPAN and its members are concerned about the effect of allowing the insurance industry to establish its own criteria for determining when it will consider provider fees to be reasonable and to be permitted to impose such a regime on all health care services without regard to significant factors and individual circumstances that accompany each no-fault case. CPAN has an interest in the so-called 80th percentile rule both as it relates to proper health care issues and as it relates to consumer issues. CPAN believes Michigan has a superior no-fault system and was formed for the very purpose of preserving quality health care and victim's rights, which are so vital to its proper functioning. Open access to health care providers, prompt and adequate medical care, reasonable choice of service, and fair and just treatment of accident victims and providers who lend care to those victims are all part of CPAN's mission.

In particular, CPAN's members are concerned that allowing the industry to refuse to pay provider fees which exceed the 80th percentile not only establishes an arbitrary definition of "reasonableness", but endangers proper health care by automatically excluding the higher cost providers who, in a competitive economy, may very well be the best at what they do, have more advanced and therefore more expensive equipment or be in greater demand for whatever reason. The Court of Appeals' decision eliminates all individual and case-specific factors and creates a definition not intended by the Legislature. Thus, CPAN urges this Court to adopt the correct interpretation of MCL 500.3107 and MCL 500.3157 which recognizes that questions of reasonableness are necessarily ones of fact to be determined on a case-by-case basis.

II. MATERIAL FACTS AND PROCEEDINGS

The facts in the instant case are fairly straightforward. This action was brought by medical providers, automobile accident victims and an organization representing patients and providers.

NAS
AMIS
FIRM
DRAMIS,
OUGHTON
TYRE, P.C.
TREE ROAD
MICHIGAN
1-4207
517-394-7500
-394-7510

Plaintiffs argued, pursuant to Sec. 3107 and 3157, that Defendants' method of calculating a reasonable fee under the No-Fault Act is impermissible. Various auto no-fault insurers have employed review companies (also defendants in this action) to "compare the insured's providers' fees to those of other providers in order to determine what is 'reasonable'". *Advocacy Organization for Patients and Providers v Allstate*, 257 Mich App 365, 369, 370 NW2d 569 (2003). Defendants refused payments above the highest rate allegedly charged by 80% of providers offering the same service. Plaintiffs asserted that Defendants' actions constituted a breach of contract and a breach of their obligations under the Act; that other actions in informing the insureds that they were not responsible for balances due above what the insurance company had determined was a reasonable charge constituted tortious interference with contractual and business relationships; and that the various defendants committed civil conspiracy.[1] Plaintiffs argued that "Defendants may not refuse to fully reimburse Plaintiff providers for covered medical expenses as long as the providers' charge is not greater than the amount that provider would charge for similar services to persons without insurance." Plaintiffs argued that Sec. 3157 of the No-Fault Act essentially required that provider fees be paid in full so long as they did not exceed the customary charge of the particular physician.

The lower court held that Defendants were entitled to review medical charges and were required to pay only those that were determined reasonable. The Court held that the "reasonableness" language of Sec. 3157 did not equate to such amount that the medical provider

[1] This matter also initially contained federal counts. The case was removed to federal court to determine the federal claims. The claims were dismissed and the matter was remanded back to state court. This in not relevant to the instant appeal, nor is it relevant to the issues existing in this appeal which are of interest to CPAN. See generally *Advocacy Organization for Patients and Providers v Allstate*, 176 F3d 315 (CA 6, 1999).

NAS
AMIS
FIRM
DRAMIS,
OUGHTON
TYRE, P.C.
TREE ROAD
MICHIGAN
1-4207
517-394-7500
-394-7510

established as his or her "customary" charge. The Court reasoned that such would violate Sec. 3107. The Court of Appeals addressed the issue of reasonableness and upheld the lower court. In so doing, however, the Court of Appeals gave its imprimatur to the method by which Defendant review companies systematically refused to pay more than "100% of the charges as long as the charge does not exceed the highest charge for the same procedure charged by 80% of other providers rendering the same service." *Id*, p. 382. The Court of Appeals stated that it would not "attempt to delineate the permissible factors for determining what is 'reasonable'" because it was not necessary in the instant case; however, it then proceeded to endorse Defendants' methodology. *Id.* The Court of Appeals declared that the practice did not violate the No-Fault Act "where the amount paid is based upon a *proper* reasonableness determination and the insurer will defend and indemnify the insured if the health care provider sues the insured for the balance." (Emphasis added.) *Id.*

While purporting not to delineate permissible factors or determine a test for reasonableness, the Court of Appeals endorsed the criterion utilized by Defendants and held that it was not precluded under case law or any particular language of the statute. *Id.*, p. 381. The Court of Appeals claimed that the 80th percentile test did not violate *Munson Medical Center v AutoClub Ins Ass'n*, 218 Mich App 375, 554 NW2d 49 (1996), which disallowed employment of a workers' compensation payment schedule to determine whether a charge was reasonable, and the court indicated that it did not violate *Hofmann v AutoClub Ins Ass'n*, 211 Mich App 55, 535 NW2d 529 (1995), which indicated that an insurer could not utilize amounts other insurers *paid* for a service to determine customary charge. Instead, the Court held that the 80th percentile test looked at amounts charged (not paid), and though based on a formula, "that formula is based upon a survey

NAS
AMIS
FIRM
DRAMIS,
OUGHTON
TYRE, P.C.
TREE ROAD
, MICHIGAN
1-4207
517-394-7500
-394-7510

of *charges* by other health care providers for the same services, a sampling which we conclude is not prohibited by the statute for determining the reasonableness of charges for the same service." (*Id.*, p. 382.) Accordingly, the court's disavowal notwithstanding, it *did* indeed "delineate" a survey of charges as a reasonable methodology.

On June 25, 2004, this Court granted leave to appeal and directed Defendants "to explain in detail the computations they use in determining whether a particular charge meets the '80th percentile test'". It is to this issue which CPAN wishes to direct the Court's attention and to which it devotes most of its discussion in its amicus brief.

III. STANDARD OF REVIEW

This case involves a question of statutory interpretation, which requires review de novo. See *McCauley v General Motors Corporation*, 457 Mich 513, 518, 578 NW2d 282 (1998).

IV. STATUTORY CONSTRUCTION

This Court has emphasized time and time again that "[t]he fundamental rule of statutory construction is to give effect to the Legislature's intent. That intent is clear if the statutory language is unambiguous, and the statute must then be enforced as written." *Weakland v Toledo Engineering Co, Inc*, 467 Mich 344, 347, 656 NW2d 175 (2003) (citation omitted). The words in a statute must be given their plain or commonly-understood meaning, but any definition the Legislature supplies in a statute controls their meaning. See MCL 8.3a; see also *Veenstra v Washtenaw Country Club*, 466 Mich 155, 159-160, 645 NW2d 643 (2002); *People v Morey*, 461 Mich 325, 330, 603 NW2d 250 (1999). The structure, subject, and context of the statute ordinarily provide information

VAS
AMIS
FIRM
DRAMIS,
OUGHTON
TYRE, P.C.
TREE ROAD
MICHIGAN
-4207
517-394-7500
394-7510

regarding this meaning See *id*; see also *People v Vasquez*, 465 Mich 83, 89, 631 NW2d 711 (2001) (Markman, J.). Not surprisingly, then, courts are bound to give effect to all the words in a statute, and if possible, harmonize any conflicts that exist See *Nowell v Titan Ins Co*, 466 Mich 478, 482, 648 NW2d 157 (2002); *Pohutski v City of Allen Park*, 465 Mich 675, 683, 641 NW2d 219 (2002).

V. THERE IS NO STATUTORY BASIS FOR IMPOSING AN 80TH PERCENTILE RULE IN PAYING PROVIDER FEES SINCE SUCH ESTABLISHES A MAXIMUM PAYMENT SCHEDULE WITHOUT REGARD TO THE REASONABLENESS OF THE FEE IN ANY PARTICULAR INSTANCE

A. The determination of what no-fault insurers are obligated to pay health care providers is set forth in the No-Fault Act.

Pursuant to Sec. 3107, MCL 500.3107, "personal protection insurance benefits are payable for...(a) Allowable expenses consisting of *all* reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation". (Emphasis added.) Thus, *all* reasonable charges must be paid. Also pertinent to this question is Sec. 3157, MCL 500.3157, which provides that "a physician...lawfully rendering treatment to an injured person for an accidental bodily injury...may charge a reasonable amount for the products, services and accommodations rendered. The charge shall not exceed the amount the person or institution customarily charges for like products, services and accommodations in cases not involving insurance." The Court of Appeals held that these two statutory provisions meant that a no-fault insurer was only required to pay a reasonable charge and that such reasonable charge could not exceed the customary charge for like services in cases not involving insurance. The Court of Appeals held that Sec. 3157 did not mean that a charge was necessarily reasonable and payable as long as it was the physician's customary charge. CPAN does not address the issue of customary charges, but, rather, addresses only the issue of utilizing the 80th percentile rule to determine a reasonable fee.

DRAMIS, OUGHTON TYRE, P.C.
TREE ROAD
MICHIGAN
1-4207
517-394-7500
-394-7510

Initially, it must be noted that the dispositive language is quite clear: the insurer must pay "all reasonable charges". In Michigan jurisprudence, including cases under the No-Fault Act, the question of reasonableness, is necessarily one of fact based on the circumstances of each case and, therefore, must be made on a case-by-case basis. The adoption of the 80th percentile rule eschews any notion that the question of a reasonable fee is a factual matter and one to be determined by the individual facts of each case. This violates the clear intent of the statute which established the issue of fees as a factual matter, not a matter subject to an arbitrarily established rule.

As the Court of Appeals suggested in *Williams v AAA Michigan*, 250 Mich App 249; 646 NW2d 476 (2002), despite the extensive body of case law regarding no-fault benefits, there is always a "novel factual wrinkle" that requires individualized attention to the specific facts of the case. *Id.* at 252; see *id.* at 259-261 (analyzing specific "circumstances" of case to determine whether obtaining fee title to renovated house as accommodation of injuries sustained in an accident was a "reasonable charge reasonably necessary for [the] plaintiff's care" under MCL 500.3107). This case-by-case focus explains why the determination whether a charge is reasonable is a question of fact for the jury to resolve on the basis of all the evidence. See *Kallabat v State Farm Mut Auto Ins Co*, 256 Mich App 146, 149, 151-152; 662 NW2d 97 (2003). Even in cases decided by the trial court, and not a jury, the court is obligated to "consider[] whether each particular expense at issue was reasonably necessary for each insured" by examining "the individual circumstances" at issue in the case. *Spect Imaging, Inc v Allstate Ins Co*, 246 Mich App 568, 576; 633 NW2d 461 (2001); see *id.* (examining record for evidence supporting each particular expense). To paraphrase the Court of Appeals in *Spect*, *supra* at 577, to hold that a percentage of a charge for reasonably necessary expenses automatically falls outside the definition of a reasonable charge as intended in MCL 500.3107 would thwart the policy underlying the statute, which requires each particular charge to be reasonable. In other words, interpreting MCL 500.3107 to allow an insurer to deny all claims above a certain amount and pay all claims below a certain amount would be simple, and yet wholly inconsistent with the Legislature's intent to have a case-by-case analysis

INAS
AMIS
W FIRM
, DRAMIS,
BOUGHTON
NTYRE, P.C.
TREE ROAD
, MICHIGAN
11-4207
517-394-7500
7-394-7510

of the reasonableness of a charge.

Case law from other areas of the law only confirms that determining what constitutes a reasonable charge depends on the particular facts of a situation, and therefore cannot be determined in advance by categorical approvals or denials of claims. This conclusion makes sense because the determination of reasonableness requires the exercise of discretion, and discretion always requires an attention to the particular facts of a case. See *Wilson v Michigan State Bd of Registration in Medicine*, 228 Mich. 25, 199 NW2d 643 (1924), quoting *Styria, Scopinich, Claimant v Morgan*, 186 US 1, 9; 22 S Ct 731; 46 L Ed 1027 (1902) (The "reasonable exercise of discretion must be considered and determined in the light of the facts in each particular case. The term discretion implies the absence of a hard and fast rule. The establishment of a clearly defined rule of action would be the end of discretion, and yet discretion should not be a word for arbitrary will or inconsiderate action.") (internal quote marks omitted); *Inverness Mobile Home Community, Ltd v Bedford Twp*, __ Mich App __; __ NW2d __ (2004), slip op at 5 (discussing deprivation of discretion in preventing determinations of reasonableness). *See also* case law on what constitutes a "reasonable" attorney fee: *Michigan Dep't of Transportation v Randolph*, 461 Mich 757, 765-768; 610 NW2d 893 (2000) (requiring fact-specific analysis of what constitutes reasonable attorneys fees under the Uniform Condemnation Procedures Act even though it will lead to different results in different cases, and rejecting lodestar as single method of analysis to be employed in all cases); *Wilson v General Motors Corp*, 183 Mich App 21, 41-42; 454 NW2d 405 (1990) (rejecting fee multiplier as a reward in a contingency fee in civil rights case because it does

INAS
RAMIS
W FIRM
, DRAMIS,
BOUGHTON
NTYRE, P.C.
E TREE ROAD
, MICHIGAN
11-4207
E 517-394-7500
7-394-7510

not reflect what is reasonable).[2]

Of course, the Court of Appeals did not even address what factors were involved in Defendants' formulation of the 80th percentile rule. Such a position is itself clear error. Absolutely no discussion of permissible considerations was entertained. In addition to this fatal error, the discussion in Part C will reveal that even if the Court of Appeals had attempted to set forth reasonable factors to consider, such factors would necessarily be so varied and subjective that any attempt to impose a set rule must fail as contrary to the language of the No-Fault Act and prior case law thereunder. It is presently noteworthy that in *Nasser v AutoClub Ins Ass'n*, 435 Mich 33, 40, 457 NW2d 637 (1990), the defendant no-fault insurer argued that "[w]hether in fact *these services* are reasonable and necessary is most definitely a question of fact for the jury to decide." Now, apparently, the no-fault insurer disagrees and, according to the Court of Appeals, these determinations can be made as a matter of law. Such a determination constitutes judicial legislation. This Court, while recognizing that there are, of course, instances where there is no dispute of any material fact and determinations can be made as a matter of law, reiterated that "the question whether expenses are reasonable and reasonably necessary is generally one of fact for the jury". *Nasser, supra*, p 55. In simply holding that there was no statutory provision which directly precluded the 80th percentile rule, the Court of Appeals committed clear error because it endorsed a reflexive application of the 80th percentile rule. Charging in the upper 20% just became unreasonable as a matter of law.

The fact of the matter is that "reasonable" is not the only significant term in Sec. 3107

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[2] Courts may rely on MRPC 1.5 to provide some of the factors relevant to determining whether fees are reasonable. See *Zeeland Farm Services, Inc v JBL Enterprises, Inc*, 219 Mich App 190, 198; 555 NW2d 733 (1996). Not all of these factors are relevant or are accorded the same weight in every case. See, generally, *Jordan v Transnational Motors, Inc*, 212 Mich App 94, 97; 537 NW2d 471 (1995). Instead, courts use a case-by-case approach, looking at the facts of the case and the elements that mitigate for or against awarding a particular fee amount. See *id.* (making a "careful review of the record" for attorney fee issue). This analysis and the discretion it requires is no different in form than the sort of analysis required under MCL 500.3107.

INAS
AMIS
W FIRM
, DRAMIS,
BOUGHTON
NTYRE, P.C.
TREE ROAD
, MICHIGAN
11-4207
517-394-7500
7-394-7510

which requires that no-fault insurers pay "all reasonable charges". Courts give words as broad as "all" their plain meaning, refusing to imply artificial limits. As the Court of Appeals said in *Calladine v Hyster Co*, 155 Mich App 175, 182, 399 NW2d 404 (1986), "there cannot be any broader classification than the word 'all', and 'all' leaves room for no exceptions." A reflexively applied rule that is based on a mathematical formula, which does not take individual circumstances into account, does not pay for "all reasonable charges". By use of the term "all" the Legislature rejected any notion of a fee schedule or of a set formula to determine a reasonable fee. If it had intended such a result, it would *not* have required that all reasonable charges be paid. This is true because each and every reasonable charge must be paid and, by necessary implication, a case-by-case analysis is required. Otherwise, the Legislature would have allowed insurers to pay "a" reasonable amount or to refuse to pay "unreasonable" charges. Any other result ignores the clear language of the statute. A physician who all would recognize as one of the more highly skilled physicians in his or her specialty is not paid for "all" of his or her reasonable charges if the insurance company is permitted to say it simply will not pay more than 80%. Proper statutory construction requires that the Court of Appeals be reversed.

B. The Court of Appeals decision impermissibly establishes a fee schedule

The Court of Appeals' opinion is internally inconsistent. It claimed that Defendants "have not employed the workers' compensation payment schedule[3], as was rejected in *Munson, supra,* to determine whether a particular charge is reasonable." It also claimed that the *Mercy Mt Clemens*

[3] It is noteworthy that PA 143 of 1993, duly enacted by the Legislature but rejected by the electorate at the polls in 1994, amended the No-Fault Act, Sec. 3157, and sought to impose a maximum fee schedule that was a percentage of workers' compensation rates. See MCL 500.3157(2)(a) and (b) from PA 143. Public Act 143 was rejected at the polls and the effect is that every provision, authorization and alteration was, as a matter of law, rejected. See *In re Proposals D and H*, 417 Mich 409, 423; 339 NW2d 848 (1983). A formula which allows drawing a line in the sand at 80% is a fee schedule. It is the same as imposing one related to a percentage of the workers' compensation rate as PA 143 did. There is no authority for it. It has been rejected numerous times by the Court of Appeals and legislative authorization was rejected by the electorate.

NAS
AMIS
FIRM
DRAMIS,
OUGHTON
TYRE, P.C.
TREE ROAD
MICHIGAN
1-4207
517-394-7500
-394-7510

Corp v AutoClub Ins Ass'n, 219 Mich App 46, 555 NW2d 871 (1996)], Court held that the amounts health care providers accepted as payment in full from various third-party payors, such as Medicare, Medicaid, Blue Cross, workers' compensation carriers, HMOs, and PPOs, were not relevant in determining whether the amounts health care providers *charged* were reasonable and customary under Sec. 3157." (Emphasis in original.) (*Id.*) The Court below implicitly held that utilizing such a system to determine reasonableness of the fee, rather than whether the fee was customary, was appropriate. An internal inconsistency, however, arises from the fact that absolutely no inquiry into the nature of the charges was ever made such that it is merely a way to circumvent the prohibitions of *Munson*, etc, and impose a fee schedule based on other health care systems.

In this connection, there is absolutely no indication of what Defendants' survey consisted. Providers have no way of knowing what the review companies relied upon other than the fact that "the formula is based upon a survey of charges by other health care providers for the same services". (Lower court opinion, p 282). In today's health-care delivery world, however, it is clear that most delivery systems for health care services are managed care, *i.e.*, an HMO, a PPO, an individual practice association, or other prepaid health plan. See *Michigan Chiropractic Society v Commissioner of Insurance*, 262 Mich App 228, 230, n. 2, ____ NW2d ____ (2004). It is a virtual certainty that the so-called survey of charges by the review companies included all of these forms of managed care, including Blue Cross, PPOs, and most likely Medicare, Medicaid and workers' compensation rates. This is nothing more than a disguised managed-care system. All rates are "surveyed" and 80% of the rate is determined to be a reasonable charge. This is what managed-care systems do. They secure a set and constant reduction in the standard rate.

The Court of Appeals' attempt to distinguish between the amount *paid* under these other systems and the amount *charged* is a distinction without meaning. The Court of Appeals wishes readers of the opinion to believe that, though the law is clear that amounts *paid* under other systems

NAS
AMIS
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DRAMIS,
OUGHTON
TYRE, P.C.
TREE ROAD
MICHIGAN
1-4207
517-394-7500
-394-7510

cannot be utilized in addressing no-fault fees, it is permissible to look at the amount *charged.* Of course, in today's world of managed-care health care, where the rate that a physician is to be paid is set by contractual arrangement, statutory fee schedule or otherwise, it is absolutely disingenuous to suggest that there is necessarily a difference between the amount charged and the amount paid. A contractual arrangement establishing the amount payable as an insurance benefit will logically affect the number of physicians who actually "charge" the non-contractual, or standard and customary, rate. The distinction between paid and charged is artificial, is of little statistical confidence and contrived. Nothing in the record suggests anything was undertaken to determine how charged fees differed from paid fees. Of course, if the charges included in the survey already reflect an agreed-upon rate (which may often times be 80% of a standard rate), then the survey has effectively chosen to pay at the 64-percentile range as the paid fee has become the charged fee.

In addition, not only is it likely that the so-called survey included PPO and HMO rates such that it violated *Munson, supra, Hofmann, supra, and Mercy Mt Clemens, supra*, but given the principles of law arising from these cases, *i.e.,* that "use of criteria imposed by other statutory schemes or contractual agreements is hereby rejected as a matter of law" (*Hofmann, supra*, p 390), it is clear that the only type of survey which would not necessarily and absolutely violate the No-Fault Act is one that involved charges for uninsured patients only. The survey, however, purports to do no such thing. Thus, the Court of Appeals' decision necessarily violates well-settled case law.

C. The Court Of Appeals incorrectly decided this case below because the 80th percentile rule is arbitrary and capricious and violates any standard for determining reasonableness which is not capable of being determined by mathematical formula.

Most important, perhaps, to recognizing the error of the Court of Appeals' decision is that the nature of a reasonable fee is inherently incapable of precise mathematical definition. Not only did the court not know of what types of providers and plans the surveyed fees consisted, but a

INAS
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, DRAMIS,
BOUGHTON
NTYRE, P.C.
TREE ROAD
, MICHIGAN
11-4207
E 517-394-7500
7-394-7510

myriad of questions remains. The decision of the Court of Appeals is dangerous in many aspects.[4] The decision is dangerous both for what is known about it and for what is unknown about it.

What is known is that those providers charging higher amounts will not be paid above the 80th percentile amount. What happens when those physicians who are in the upper 20% decline to participate in the no-fault system because they have a fee dispute with each and every no-fault insured? If every no-fault case results in a dispute, non-participation is a reasonably likely result in a not so insignificant number of cases. Does the 80th percentile soon become the 100th percentile, and so on and so on? And, the question arises as to why these individuals are in the top 20%. In a competitive economy, it may reasonably be assumed that these physicians often represent the finest and most skilled. What is known is that, while every physician charging in the top 20% does not necessarily do so based on skill and will not necessarily fall within this class, *all of the highly skilled, expert physicians whose services are reasonably charged out at a higher rate* will become *de facto* ineligible for no-fault patients.

It is also known that in addition to skill, other factors may impact reasonably upon any given fee. Availability and access to the provider, *i.e.* the demand for his or her services, is clearly a competitive and acceptable factor. There is simply no way that an 80th percentile rule can take the quality of the provider and the service into account and certainly there is no justification for allowing the no-fault insurer to make this determination by fiat. Why 80%? Does that meet some universally recognized axiom on reasonableness? If reasonable people could disagree and some

[4] Before addressing the specific pitfalls, there are obviously general questions: Who conducted the so-called study? How many participants were there? Were Medicare patients or rates included, PPO patients or rates, and workers' compensation rates? From what geographic region were the data gathered, and how was such region delineated? These are all questions that would be relevant to any particular study or survey that will have the effect of creating a statutory definition. The enumeration discussed further in the text of this brief relates specifically to the review companies' "survey".

INAS
AMIS
W FIRM
, DRAMIS,
BOUGHTON
NTYRE, P.C.
TREE ROAD
, MICHIGAN
11-4207
E 517-394-7500
7-394-7510

would say the 85th percentile is a "reasonable" demarcation, then the 80th percentile rule violates the clear language of the statute by failing to compensate for "all reasonable charges".

Similarly, it is a known factor that the quality of support personnel in an office, including the number of support staff, and the state of the equipment (and therefore quality and cost) also enter into the equation. Further, it may be recognized that special training, additional education or special licensing and credentialing of a health care provider will reflect upon whether the fee charged is reasonable under the circumstances in that it will also reflect upon the skill, cost and ultimate value involved in any particular service. It is known that none of these considerations has been taken into account with respect to the survey at issue.

What is left unknown by the decision is how the number of like providers and the amount of competition in any locale can be factored into the equation. Is an insured and, therefore, the insurance company billed an unreasonable amount because the insured could have driven 20 miles further to see a different physician whose charge was at a lower rate (largely because of the existence of other providers of the same service in that area)? It is also unknown what class of health care providers was included in the survey, and the existence of other potentially similar services in the market which would necessarily bear upon the cost. Critically, however, the survey did not seek to take the complexity of each individual case into account, or the degree of skill required for proper treatment. Setting a broken ankle or adjusting a spine is not the same in every instance. The No-Fault Act does not require the insured to accept the service of only those physicians charging at the 80 percentile mark or less.

Each and every situation has its own attendant facts and circumstances which must be taken into account. How old is the insured? What type of medical history is involved? What complicating and mitigating factors are present? And, a factor which is still relevant, with whom does the patient feel most comfortable and confident? In a nutshell, age, training, skill, experience,

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patient preference, geographic location, competitive cost, competitive forces, state-of-the-art equipment all are relevant, *to name a few*.

The list could go on and on. Temporally speaking, is yesterday's so-called reasonable rate viable today? How is relative cost of living for any given area taken into account? These are relevant, but not exclusive, considerations that may bear upon the reasonableness of any fee. The reasonableness question can only realistically be dealt with on a case-by-case basis, taking into account those factors which are relevant under the circumstances. There is no basis for determining that the Legislature intended a precisely-drawn mathematical formula to apply to the question of "reasonableness". Even if all of these factors could be taken into account properly, the reflexive application of any set formula violates legislative intent. It is well settled that the determination of reasonableness is a question of fact for the jury. *Nasser, supra*; *Anton v State Farm*, 238 Mich App 673, 687 (1999). Black's Law Dictionary, 6th Ed, defines "reasonable" in its first sentence, p 1265, as "[f]air, proper, just, moderate, suitable *under the circumstances*." (Emphasis added.) Application of any simple formula defies the very concept of "reasonable" which must necessarily take into account the circumstances of each given case.

VI. CONCLUSION

For the foregoing reasons, Amicus Curiae CPAN respectfully requests that this Court overturn the decision of the Court of Appeals and declare that the question of reasonableness must be determined on a case-by-case basis taking into account the particular circumstances of each insured and injury.

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